



Identify of Preoperative and Postoperative Complication of Planned Management and Emergency Management of Patients with PAS Disorder

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Abstract: **Background:** Placenta accreta spectrum (PAS) often results in significant blood loss and peripartum hysterectomy; the mother may not survive. In many cases, timely prenatal diagnosis allows for careful birth planning in a specialized facility with a highly qualified multidisciplinary team. This has been shown to reduce maternal morbidity. Scheduled deliveries are associated with lower rates of bleeding and emergency procedures when compared to emergency deliveries. **Objective:** The aim of this study is to identify the preoperative and postoperative complication of planned management and emergency management of patients with PAS disorder. **Methods:** The cross-sectional comparative study was conducted in the Department of Obstetrics & Gynaecology, Dhaka Medical College Hospital, Dhaka from 18th January 2020 to 17th July 2020. A total of 84 patients diagnosed as a case of PAS disorder (antenatally and peroperative diagnosed) and scheduled for planned management or emergency management of PAS were included according to inclusion and exclusion criteria. 42 planned management of PAS disorder patients as Group A and 42 emergency management of PAS disorder patients as Group B. The questionnaire was pretested, corrected and finalized. Data were collected by face-to-face interview and analyzed by appropriate computer based programmed software Statistical Package for the Social Sciences (SPSS), version 24. **Results:** In this study, mean \pm SD of age was calculated 26.3 ± 4.3 years for Group - A and 28.1 ± 3.2 years for Group - B. Urban population were predominant in group-A. About 30 (70.0%) patients in group-A and 10 (23.8%) patients in group-B came from urban. Large number of respondents 22 (52.4%) and 10 (50.0%) were housewife in both groups. Among the patients, the lower class 18 (42.9%) and 23 (54.8%) comprised the major percentage of the patients

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in both groups. More participants in Group-A 29 (69.00%) received ANC regularly than Group B 10 (23.80%), the difference was statistically significant ($p < 0.05$). In group-A maximum patients presented with only USG findings of PAS disorders and with APH or without APH 26 (61.8%). In group-B, PPH and internal haemorrhage 10 (23.8) was noted predominantly. The mild anemia was more in 23 (54.8%) patients in group A and 16 (38.1%) patients in group B which was statistically significant ($p < 0.001$). More participants in Group-B 26 (61.9%) required early termination, whereas majority of group A 35 (83.3%) was terminated at 35-36 weeks. There was a statistically significant difference between groups. Maximum patients were managed by peripartum hysterectomy 35 (82.0%) and 31 (73.8%) in group A & B respectively. Presence of multidisciplinary team was arranged in 38 (90.4%) in group A and 18 (42.9%) in group B. General anesthesia and CV line was given in 36 (85.7%) patients in group-A and 27 (64.3%) patients in group-B. Massive blood transfusion was needed in 23 (54.8%) patients in Group B & only 3 (7.1%) patients in Group A. Placenta accreta was present 11 (26.2%) patients in group A and 7 (16.7%) patients in group B. Placenta percreta with bladder invasion and peroperative bladder injury was higher in group-B patients. More than 3 L blood was transfused 3 (7.1%) patients in group A and 23 (54.8%) patients in group B. PPH, Sepsis, Re-exploration, DIC and ICU admission were the significant complication in Group-B patients, reported 41 (95.0), 4 (9.5%), 8 (19.0%), 9 (21.4%) and 21 (50.0%) of women and in less complication in Group A 13 (31.0), 0%, 0%, 1 (2.3) and 4 (9.5). In this study mortality rate was 2 (4.8%) in group-B (due to irreversible shock & DIC). Poor outcomes were significantly higher in group-B. NICU admission for prematurity was required in 9 (21.4%) of the babies in group-A and 23 (54.8%) babies of group-B. Birth asphyxia was observed in 4 (9.5%) of the babies in group-A and 13 (31.0%) in Group-B.

Conclusion: Prenatal diagnosis and placenta preservation may be linked to lower rates of morbidity in mothers. For morbidly adherent placenta linked with placenta previa, we advise hysterectomy as the preferred course of therapy following extremely thorough prenatal counseling. Maternal problems and fetal outcomes may be improved by early risk factor identification and proactive management.

Keywords: Complication, Planned Management, Emergency Management, PAS Disorder.

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INTRODUCTION

Placenta accreta spectrum (PAS) is increasing in incidence and will become more frequently encountered [1]. PAS carries a substantial risk of morbidity and mortality due to the possibility of large hemorrhage. It should be handled in a specialized center with the necessary resources and competence. It has been demonstrated that early diagnosis, a multidisciplinary team (MDT) approach, and better outcomes reduce maternal hemorrhage and blood transfusion needs [2, 3]. Obstetricians, midwives, anesthetists, operating department practitioners, haematologists, transfusion practitioners, neonatologists, interventional radiologists, and critical care staff are among the pertinent members of the MDT.

The most frequent reason for peripartum hysterectomy is PAS, which is linked to a higher risk of major transfusion, critical care hospitalization,

extended operation, and length of hospital stay [1, 4]. A number of surgical techniques are explained to treat PAS. One such surgery, known as the "Triple P procedure," attempts to prevent morbidity, preserve fertility, and lower the likelihood of peripartum hysterectomy [5].

The anesthetist's goal during an operational delivery is to maximize the surgeons' working conditions while giving the patient a safe, pleasant, and happy birthing experience. Delivering these goals is made more difficult by PAS because of a number of intricate surgical challenges, including as managing severe bleeding and the related coagulopathy and quickly altering physiological issues. The anesthetic concerns for the perioperative care of patients with PAS undergoing cesarean delivery are covered in this review.

Following a diagnosis of PAS, the patient should be evaluated by the surgical team in order to

establish a surgical care plan and schedule the delivery. Unless a clinical requirement necessitates an earlier intervention, surgery is typically scheduled between 35 and 37 weeks of pregnancy. Together with the anesthetic, haematology, interventional radiology (IR), neonatology, midwifery, transfusion, and critical care teams, the MDT creates the perioperative strategy [5]. Because of their preterm and intrauterine development limitation, infants born to individuals with PAS are more likely to need intensive care and resuscitation [6].

The postoperative treatment may require Additional fluid resuscitation, coagulopathy correction, Handling perioperative hypofibrinogenaemia: this puts an additional strain on continued bleeding and needs to be addressed and rectified in collaboration with surgeons and the haematology unit.

Identifying and treating complications with arterial catheters: limb ischaemia that requires immediate revascularization, local hemorrhage, nerve ischaemia, artery damage, vaginal necrosis, contrast allergy, and pain are just a few of the issues that have been documented in the literature. If the interventional radiology team determines that the patient needs immediate revascularization, anesthesia participation is more likely. In order to prevent unintentional consequences, a protocol for deflating balloons and removing catheters must be followed. The timing of VTE thromboprophylaxis is still important, even when PAS surgery is involved. Compression boots are used to do this mechanically during surgery. The removal of the intra-arterial and epidural balloon catheters on the first postoperative day coincides with the timing of the pharmacological regimen.

METHODOLOGY

The cross-sectional comparative study was conducted in the Department of Obstetrics &

Gynaecology, Dhaka Medical College Hospital, Dhaka from 18th January 2020 to 17th July 2020. A total 84 patients diagnosed as a case of PAS disorder (antenatally and peroperative diagnosed) and scheduled for planned management or emergency management of PAS were included according to inclusion and exclusion criteria. 42 planned management of PAS disorder patients as Group A and 42 emergency management of PAS disorder patients as Group B. Patients who were not willing to give consent were excluded. Purposive sampling was done according to the availability of the patients who fulfilled the selection criteria. Face to face interview was done to collect data with a semi-structured questionnaire. After collection, the data were checked and cleaned, followed by editing, compiling, coding, and categorizing according to the objectives and variables to detect errors and to maintain consistency, relevancy and quality control. Statistical evaluation of the results used to be obtained via the use of a window-based computer software program devised with Statistical Packages for Social Sciences (SPSS-24).

RESULT

Table I shows that, mean ± SD of age was calculated 26.3 ± 4.3 years for Group – A and 28.1 ± 3.2 years for Group – B. (p-value = 0.863) which explains that there was no significant statistical difference between the groups was observed. Urban populations were predominant in group-A. About 30 (70.0%) patients in group-A and 10 (23.8%) patients in group-B came from urban, the difference was statistically significant (p<0.05). Large number of respondents 22 (52.4%) and 10 (50.0%) were housewife in both groups. among the patients, the lower class 18 (42.9%) and 23 (54.8%) comprised the major percentage of the patients in both group, which is followed by middle class 15 (35.7%) and 14 (33.3%) and remaining are upper class 9 (21.4%) and 5 (11.9%) in both group.

Table I: Distribution of the patients according to age (n = 84)

Age (years)	Group-A (n=42)	Group-B (n=42)	p-value
20 - 25	11 (26.2)	8 (19.4)	0.863
26 - 30	16 (38.1)	19 (45.2)	
31 - 35	9 (21.4)	10 (23.8)	
≥35	6 (14.3)	5 (11.9)	
Mean ± SD	26.3 ± 4.3	28.1 ± 3.2	
Residence			
Urban	30 (70.0)	10 (23.8)	<0.05
Rural	12 (30.0)	32 (76.2)	
Occupation			
Service holder	4 (9.5)	1 (2.4)	
Housewife	22 (52.4)	23 (54.8)	
Day Laborer	10 (23.8)	13 (31.0)	
Unemployed	6 (14.3)	5 (11.9)	

Age (years)	Group-A (n=42)	Group-B (n=42)	p-value
Socioeconomic status			
Upper	9 (21.4)	5 (11.9)	
Middle	15 (35.7)	14 (33.3)	
Lower	18 (42.9)	23 (54.8)	

Figure I shows that, more participants in Group-A 29 (69.00%) received ANC regularly than

Group B 10 (23.80%), the difference was statistically significant ($p < 0.05$).

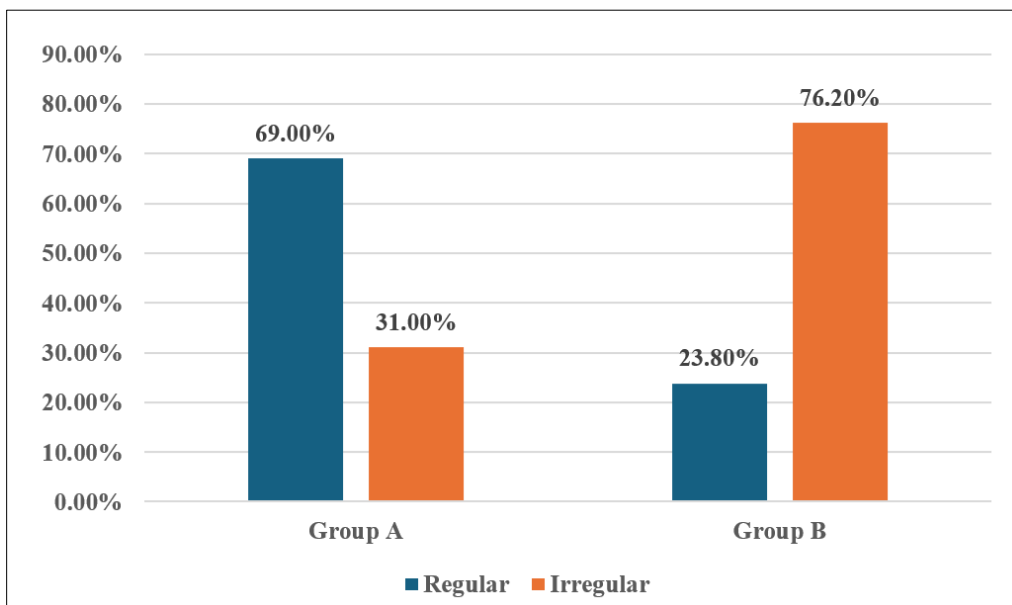


Figure I: Distribution of the patients according to trend of antenatal care received by patients (n = 84)

Table II shows that, pattern of presentation of PAS disorder. In group-A maximum patients presented with only USG findings of PAS disorders and with APH or without APH 26 (61.8%) Result was

significant. In group-B, PPH and internal haemorrhage 10 (23.8) was noted predominantly. Result was significant.

Table II: Distribution of the patients according to pattern of presentation of PAS disorder (n = 84)

Presentation pattern	Group-A (n=42)	Group-B (n=42)	p-value
A) Diagnosed antenatally with USG with or without APH			
Only USG findings of PAS disorder	10 (23.8)	0	0.006
Mild APH with USG findings of PAS disorder	8 (19.0)	0	0.009
Moderate APH with haemodynamic status stable with USG findings of PAS disorder	8 (19.0)	17 (40.4)	0.215
B) Diagnosed peroperatively			
Severe APH with haemodynamically unstable with peroperative findings of PAS disorder	3 (7.1)	16 (38.1)	0.002
Scar tenderness (peroperative findings of PAS disorder)	7 (16.7)	9 (21.4)	0.736
Only PROM with peroperative findings of PAS disorder	2 (4.8)	3 (7.1)	0.983
C) Primary c-section outside DMCH			
PPH	0	5 (11.9)	0.041
Internal haemorrhage	0	5 (11.9)	0.041

Figure II shows that, the mild anemia was more in 23 (54.8%) patients in group A and 16 (38.1%) patients in group B which was statistically significant ($p < 0.001$). Similarly, severe anemia was

higher in group-B patients 15 (35.7%) and 2 (4.8%) in group A. The difference was statistically significant ($p > 0.108$).

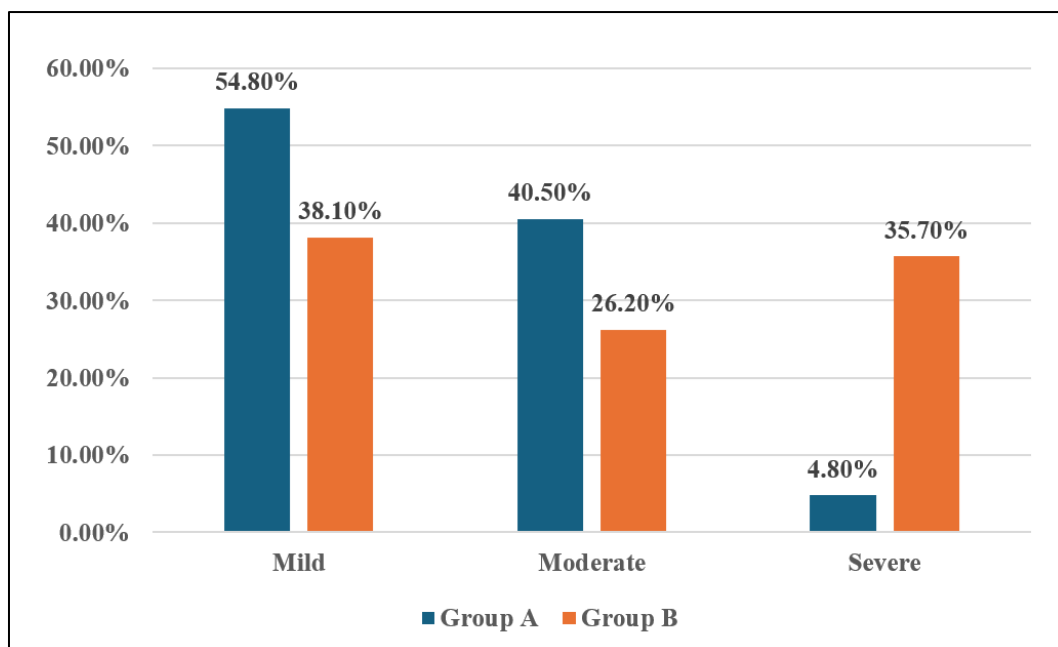


Figure II: Distribution of the patients according to status of anemia (n = 84)

Table III shows that, more participants in Group-B 26 (61.9%) required early termination, whereas majority of group A 35 (83.3%) was

terminated at 35-36 weeks. There was a statistically significant difference between groups.

Table III: Distribution of the patients according to Gestational age of termination (n = 84)

Gestational age of termination	Group-A (n=42)	Group-B (n=42)	p-value
28-30 weeks	0	3 (7.1)	<0.05
32-34 weeks	7 (16.7)	26 (61.9)	
35-36 weeks	35 (83.3)	13 (31.0)	

Table IV shows that, maximum patients were managed by peripartum hysterectomy 35 (82.0%) and 31 (73.8%) in group A & B respectively. Stepwise devascularization& resuturing of placental bed was done in 4(9.5%) cases in group A & 3 (7.1%) in group

B. Ballon tamponade was done in 2(4.8%) patients in group A & 5 (11.9%) patients in group B. Tripple procedure was done in 1(2.4%) patient in group A & 3 (7.1%) patients in group B. The difference was statistically significant.

Table IV: Distribution of the patients according to operative procedure (n = 84)

Operative procedure	Group-A (n=42)	Group-B (n=42)
Peripartum hysterectomy	35 (82.0)	31 (73.8)
Stepwise devascularization& resuturing of placental bed	4(9.5)	3 (7.1)
Ballon tamponade	2(4.8)	5 (11.9)
Tripple procedure	1(2.4)	3 (7.1)

Table V shows that, Presence of multidisciplinary team (fetomaternal specialist, senior obstetrician, ICU specialist, urologist, neonatologist, etc) was arranged in 38 (90.4%) in group A and 18 (42.9%) in group B. General anesthesia and CV line was given in 36 (85.7%)

patients in group-A and 27 (64.3%) patients in group-B. Massive blood transfusion was needed in 23 (54.8%) patients in Group B & only 3 (7.1%) patients in Group A. The difference was statistically significant.

Table V: Distribution of the patients according to preoperative & peroperative intervention (n = 84)

Variables	Group-A (n=42)	Group-B (n=42)	p-value
Presence of multidisciplinary team	38 (90.4)	18 (42.9)	0.001
General anesthesia and CV line	36 (85.7)	27 (64.3)	0.005
Blood transfusion Whole blood 1-2 L	31 (73.8)	8 (19.4)	0.582

Variables	Group-A (n=42)	Group-B (n=42)	p-value	
	Whole blood 3-4 L	7 (16.7)	13 (31.0)	0.241
	Whole blood 5-6 L	3 (7.1)	23 (54.8)	0.358
	Large volume >10 L	0	2 (4.8)	0.891
	Fresh frozen plasma	11 (26.2)	39 (92.9)	0.001
Use of oxytocic's drugs	9 (21.4)	15 (35.7)	0.386	

Table VI shows that, Placenta accreta was present 11 (26.2%) patients in group A and 7 (16.7%) patients in group B. Placenta percreta with bladder invasion and peroperative bladder injury was higher

in group-B patients. More than 3 L blood was transfused 3 (7.1%) patients in group A and 23 (54.8%) patients in group B.

Table VI: Distribution of the patients according to peroperative findings (n = 84)

Variables	Group-A (n=42)	Group-B (n=42)	p-value	
Placenta accreta	11 (26.2)	7 (16.7)	0.252	
Placenta increta	12 (28.6)	8 (19.0)	0.292	
Placenta percreta without bladder invasion	14 (33.3)	13 (31.0)	0.802	
Placenta percreta with bladder invasion	7 (16.7)	19 (45.2)	0.016	
Peroperative bladder injury	7 (16.7)	19 (45.2)	0.016	
Blood loss	1-1.5 L	32 (76.2)	8 (19.0)	0.001
	2-3 L	7 (16.7)	11 (26.2)	0.386
	>3 L	3 (7.1)	23 (54.8)	0.001

Table VII shows that, PPH, Sepsis, Re-exploration, DIC and ICU admission were the significant complication in Group-B patients, reported 41 (95.0), 4 (9.5%), 8 (19.0%), 9 (21.4%) and 21 (50.0%) of women and in less complication in

Group A 13 (31.0), 0%, 0%, 1 (2.3) and 4 (9.5). In this study mortality rate was 2 (4.8%) in group-B (due to irreversible shock & DIC). So planned or scheduled management had better outcome.

Table VII: Distribution of the patients according to postoperative complications (n = 84)

Postoperative complications	Group-A (n=42)	Group-B (n=42)	p-value
Uneventful	24 (57.1)	18 (42.9)	0.232
Primary PPH	13 (31.0)	36 (85.7)	0.001
Secondary PPH	0	5 (11.9)	0.037
ICU admission	4 (9.5)	21 (50.0)	0.001
Delayed hysterectomy	0	0	-
Sepsis	0	4 (9.5)	0.031
Re-exploration	0	8 (19.0)	0.002
Uterovaginal fistula	0	3 (7.1)	0.142
DIC	1 (2.3)	9 (21.4)	0.005
Pulmonary oedema	1 (2.3)	4 (9.5)	0.043
Shock	1 (2.3)	4 (9.5)	0.043
Mortality (due to irreversible shock & DIC)	0	2 (4.8)	0.200

Table VIII shows that, poor outcomes were significantly higher in group-B. NICU admission for prematurity was required in 9 (21.4%) of the babies

in group-A and 23 (54.8%) babies of group-B. Birth asphyxia was observed in 4 (9.5%) of the babies in group-A and 13 (31.0%) in Group-B.

Table VIII: Distribution of the patients according to neonatal outcome (n = 84)

Neonatal outcome	Group-A (n=42)	Group-B (n=42)	p-value
NICU admission for prematurity	9 (21.4)	23 (54.8)	0.003
Birth asphyxia	4 (9.5)	13 (31.0)	0.027
IUGR	2 (4.8)	5 (11.9)	0.062
Neonatal death	1 (2.4)	7 (16.7)	0.001
No complication	28 (66.7)	7 (16.7)	0.004

DISCUSSION

A total of 84 cases of placental Accreta were recruited in this study and described the planned & emergency management and observed the fetomaternal outcomes of placenta accreta spectrum (PAS) disorders in a tertiary level hospital. In this study, mean \pm SD of age was calculated 26.3 ± 4.3 years for Group – A and 28.1 ± 3.2 years for Group – B. (p -value = 0.863) which explains that there was no significant statistical difference between the groups was observed. Urban population were predominant in group-A. About 30 (70.0%) patients in group-A and 10 (23.8%) patients in group-B came from urban, the difference was statistically significant ($p < 0.05$). Large number of respondents 22 (52.4%) and 10 (50.0%) were housewife in both groups. among the patients, the lower class 18 (42.9%) and 23 (54.8%) comprised the major percentage of the patients in both group, which is followed by middle class 15 (35.7%) and 14 (33.3%) and remaining are upper class 9 (21.4%) and 5 (11.9%) in both groups. More participants in Group-A 29 (69.00%) received ANC regularly than Group B 10 (23.80%), the difference was statistically significant ($p < 0.05$).

The results aligned with the outcomes of previous investigations. In a particular study, the mean age of mothers was 31.6 (17–46) years, with 29.3% (n¼96) of them being over 35 at the time of delivery. 187 women—or 57%—were multiparas [7]. Age has been identified as a risk factor for PAS in another investigation; 69.7% of the patients had an age above 30 [8]. Age is thought to be a higher risk factor for placenta accreta, which is linked to older mothers, according to research by Williams MA, *et al*, (1993). The uteroplacental blood flow may be impaired in elderly women. Microscopic examinations of placentae from elderly women have demonstrated extensive placental infarcts and uteroplacental under perfusion, supporting this [9]. Eniola AO, Bako AU, *et al*, (2002) also demonstrated the association between increasing maternal age & risk of development of PAS [10].

In group-A maximum patients presented with only USG findings of PAS disorders and with APH or without APH 26 (61.8%) Result was significant. In group-B, PPH and internal haemorrhage 10 (23.8) was noted predominantly. Result was significant. The mild anemia was more in 23 (54.8%) patients in group A and 16 (38.1%) patients in group B which was statistically significant ($p < 0.001$). Similarly, severe anemia was higher in group-B patients 15 (35.7%) and 2 (4.8%) in group A. The difference was statistically significant ($p > 0.108$). More participants in Group-B 26 (61.9%) required early termination, whereas majority of group A 35 (83.3%) was terminated at 35-36 weeks. There was a statistically

significant difference between groups. Maximum patients were managed by peripartum hysterectomy 35 (82.0%) and 31 (73.8%) in group A & B respectively. Stepwise devascularization & resuturing of placental bed was done in 4(9.5%) cases in group A & 3 (7.1%) in group B. Ballon tamponade was done in 2(4.8%) patients in group A & 5 (11.9%) patients in group B. Tripple procedure was done in 1(2.4%) patient in group A & 3 (7.1%) patients in group B. The difference was statistically significant. Presence of multidisciplinary team was arranged in 38 (90.4%) in group A and 18 (42.9%) in group B. General anesthesia and CV line was given in 36 (85.7%) patients in group-A and 27 (64.3%) patients in group-B. Massive blood transfusion was needed in 23 (54.8%) patients in Group B & only 3 (7.1%) patients in Group A. The difference was statistically significant. Placenta accreta was present 11 (26.2%) patients in group A and 7 (16.7%) patients in group B. Placenta percreta with bladder invasion and peroperative bladder injury was higher in group-B patients. More than 3 L blood was transfused 3 (7.1%) patients in group A and 23 (54.8%) patients in group B. PPH, Sepsis, Re-exploration, DIC and ICU admission were the significant complication in Group-B patients, reported 41 (95.0), 4 (9.5%), 8 (19.0%), 9 (21.4%) and 21 (50.0%) of women and in less complication in Group A 13 (31.0), 0%, 0%, 1 (2.3) and 4 (9.5). In this study mortality rate was 2 (4.8%) in group-B (due to irreversible shock & DIC). Poor outcomes were significantly higher in group-B. NICU admission for prematurity was required in 9 (21.4%) of the babies in group-A and 23 (54.8%) babies of group-B. Birth asphyxia was observed in 4 (9.5%) of the babies in group-A and 13 (31.0%) in Group-B.

This study's statistically significant p value of less than 0.00012 was in line with other studies' findings that prior cesarean births are associated with an increased risk of PAS [8]. According to all of these investigations, patients who had prior C/S deliveries were more likely to develop PAS [11-13]. According to the majority of research, as the frequency of C/S deliveries increased, a dose-related response pattern of placenta accreta risk variables was discovered.

According to a different study, endometriosis and assisted reproduction histories were linked to PAS. In patients with placenta praevia, nearly half (49.1%) had undergone uterus surgery before. Clearly, cesarean sections were the most common surgical history [7]. Generally speaking, it appears to be crucial to steer clear of primary CS if feasible, particularly if future fertility is desired. Cesarean sections are only carried out in our facility when necessary. Nonetheless, a significant portion of

cesarean deliveries may have been carried out at the request of the mother at other provincial hospitals, particularly the private ones, which undoubtedly contributed to the rise in these interventions [7].

It is important to highlight the higher risk of placental diseases in subsequent pregnancies while obtaining informed permission for a cesarean operation. Research points to a relationship between the number of prior C-sections and the incidence of hysterectomy, uterine rupture, and placenta praevia. As a result, following a cesarean delivery, vaginal birth may be encouraged and consenting patients may be sent to facilities with sufficient training. In our study population, a significant portion of the women had undergone curettage as a result of abortions. Less intrusive methods may be beneficial for these patients [14, 15], such as using misoprostol for medical therapy of missed abortions when it meets personal and clinical requirements [16].

Preterm deliveries were much more common in women with PAS condition [17]. Additionally, studies revealed a greater rate of stillbirths, mortality, and admissions to the neonatal intensive care unit [18]. Adverse maternal (34.15%) and neonatal (60.06%) outcomes were linked to placenta accreta [5]. The antepartum bleeding rate was 42.3%, the maternal anemia rate was 30%, the need for a hysterectomy was 82%, and the fetal mortality rate was 1.5%. Preterm births, low birth weights under 2500 g, low APGAR scores after five minutes, and low birth weights were among the common neonatal complications associated with PAS disorder with placenta praevia [17]. In another study, the outcomes for newborns of women with PAS problems were much poorer [7].

When birth is carried out with optimal treatment by a thorough multidisciplinary care team experienced in placenta accreta spectrum management, outcomes are enhanced. Decisions about when to birth a baby must weigh the benefits and hazards to the mother as well as the unborn child. Emergency surgery or unplanned intervention raise the risk of consequences such as deep brain injury, shock, and diabetic ketoacidosis. Although cesarean or peripartum hysterectomy is the gold standard treatment for invasive accreta, there is still a significant risk of severe maternal morbidity (40–50%) associated with this procedure. Due to injury to the pelvic organs, most commonly the bladder, and the vasculature, the fatality rates can reach 7% [19–22]. While individual factors are important, a multidisciplinary team care plan at 34–36 weeks gestational age, which is the preferred gestational age for scheduled C/S or hysterectomy following corticosteroid administration for fetal lung maturity,

showed a reduction in emergency deliveries from 23–64 percent without negatively affecting the outcomes for the newborn. Maternal outcomes are improved when a cesarean delivery is performed before the commencement of labor and is promptly followed by a cesarean hysterectomy [23]. In situations including ongoing bleeding, preeclampsia, labor, membrane rupture, fetal compromise, or the emergence of maternal comorbidities, an earlier delivery may be necessary. Therefore, in order to minimize the related maternal and neonatal difficulties, the screening and management of placenta Accreta Spectrum Disorder (PASD) should be planned, carried out, and carefully evaluated with timely delivery.

CONCLUSION

Prenatal diagnosis and placenta preservation may be linked to lower rates of morbidity in mothers. We found a low rate of effective uterine preservation, a low rate of maternal complications, and a generally favorable fetal outcome in our analysis. For morbidly adherent placenta linked with placenta previa, we advise hysterectomy as the preferred course of therapy following extremely thorough prenatal counseling. Women who have a strong desire to become pregnant and those whose condition is too advanced for a primary hysterectomy to be performed safely should be treated conservatively. Strategic management and early risk factor identification may enhance the results for both the mother and the fetus.

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